Department of Veterans Affairs
Office of Inspector General

MAJOR MANAGEMENT CHALLENGES
FISCAL YEAR 2006

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VA Office of Inspector General
Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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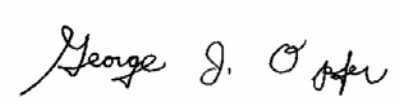
DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

Foreword

The Office of Inspector General (OIG) conducts a program of audits, inspections, and investigations in order to identify and eliminate waste, fraud, and abuse in VA programs and operations. OIG provides independent oversight of VA's mission-critical activities and programs. Every year, as required by the *Reports Consolidation Act of 2000*, Public Law 106-531, OIG provides VA with an update summarizing the most serious management problems identified by OIG work, as well as an assessment of the Department's progress in addressing them. In turn, VA program officials provide the current status of progress in these areas.

This report contains the updated summation of major management challenges organized by the five OIG strategic goals—health care delivery, benefits processing, financial management, procurement practices, and information management—and includes VA's progress report on implementing OIG recommendations. VA will also publish these challenges and responses as part of its annual Performance and Accountability Report.

OIG will continue working with VA until each of these issues is resolved. Together we can ensure that the Department will provide the best possible service to the Nation's veterans and their dependents in an efficient and effective manner, and that OIG recommendations continue to assist VA in becoming the best-managed service delivery organization in Government.



George J. Opfer
Inspector General

FY 2006 MAJOR MANAGEMENT CHALLENGES

MAJOR MANAGEMENT CHALLENGES

The Office of Inspector General (OIG) identified the major management challenges facing VA and provided the following descriptions of the challenges. Left uncorrected, these challenges have the potential to impede VA's ability to fulfill its program responsibilities and ensure the integrity of operations. For the most part, the challenges are not amenable to simple, near-term resolution and can only be addressed by a concerted, persistent effort, resulting in progress over a long period of time. *(In this report, years are fiscal years (FY) unless stated otherwise.)*

Challenges Identified by VA Office of Inspector General

OIG's strategic planning process is designed to identify and address the key issues facing VA. OIG focused on the key issues of health care delivery, benefits processing, financial management, procurement, and information management in the 2005–2010 OIG Strategic Plan. The following summaries present the most serious management problems facing VA in each area and assess the Department's progress in overcoming them. While these issues guide our oversight efforts, we continually reassess our goals and objectives to ensure that our focus remains relevant, timely, and responsive to changing priorities. *(On these pages, the words "we" and "our" refer to OIG. OIG comments in this report are up-to-date as of November 2006; VA responses were submitted in September 2006.)*

OIG #1—HEALTH CARE DELIVERY

OIG #1A—Access to Long-Term Health Care in Community Settings

Congress recognized the complexity of providing long-term care to VA's expanding aging population when it enacted the *Veterans Millennium Health Care and Benefits Act of 1999*, Public Law (P.L.) 106-117, to provide for non-institutional health care in community settings. The law directed the Secretary of VA to provide a variety of extended services to eligible veterans, including nursing home care (NHC), in either VA or community-based facilities.

- OIG reported on completed reviews of the Veterans Health Administration (VHA) Community Nursing Home (CNH) program, *Healthcare Inspection, Evaluation of the Veterans Health Administration's Contract Community Nursing Home Program*, Report No. 02-00972-44, on December 31, 2002; Homemaker/Home Health Aide (H/HHA) program, *Healthcare Inspection, Evaluation of Veterans Health Administration Homemaker and Home Health Aide Program*, Report No. 02-00124-48, on December 18, 2003; and Community Residential Care (CRC) program, *Healthcare Inspection, Veterans Health Administration's Community Residential Care Program*, Report No. 03-00391-138, on May 3, 2004. We identified long-term health care issues warranting attention in all three reviews. As of November 2006, one recommendation remains open for the CNH program review, two for the H/HHA program review, and four for the CRC program review.

VA's Program Response to OIG #1A: VA's estimated resolution timeframe is FY 2007. FY 2006 actions and next steps planned for FY 2007 are as follows:

FY 2006 Actions

- VHA provided updated CNH information on extended nursing home services to OIG in June 2006.
- VHA published the Home Health Care Handbook in July 2006.
- Geriatrics and Extended Care (GEC) referral information was published near the end of 2006.
- The CRC Handbook is in the final internal concurrence process.
- VHA has implemented the GEC referral form, which VA initiates for all veterans needing long-term care services. The form identifies the veteran's need for NHC and the spectrum of non-institutional long-term care services.
- A GEC team reviewed all referral forms and recommended placement based on documented need for long-term care services including NHC.
- Based on veteran needs and specific capabilities of nursing homes both in VA and in the community to provide the services, veterans were placed where the most appropriate, least restrictive care could be provided.
- VHA believes that these actions should close out the remaining recommendations.

Next Steps Planned for FY 2007

- GEC will continue to review and refine referral information.
- GEC will publish a Federal regulation on fire safety on the CRC program.

OIG #1B—Access to Health Care in VA Medical Facilities

OIG issued Report No. 05-03028-145, *Review of Access to Care in the Veterans Health Administration*, dated May 17, 2006, on VHA's process to ensure that all eligible and enrolled veterans with a clinical need had adequate access to care. We assessed whether veterans had access to non-institutional care and whether veterans who desired care were enrolled and provided timely care.

- OIG found that some medical facilities limited access of certain non-institutional care services to only the highest priority veterans. We also found that eligible veterans' demand for access to non-institutional health care has increased since 2003, and additional demand could be met if VHA fully funded the projected workload for non-institutional care. Also, VHA needs to develop metrics to determine whether its geriatric evaluation program is meeting the requirements of the *Veterans Millennium Health Care and Benefits Act of 1999*, P.L. 106-117.
- VA medical facilities did not have effective controls to ensure that all newly enrolled veterans in need of care received it within VHA's goal of 30 days of the desired date of care, or veterans received clinically indicated specialty procedures within a reasonable time.
- OIG made nine recommendations to VA to monitor the demand for non-institutional care, direct facilities to implement tracking mechanisms to identify newly enrolled veterans, and establish standardized tracking methods and appropriate performance

metrics. As of November 2006, all nine recommendations remain open. OIG will close the recommendations upon receipt of documentation ensuring that facilities have eliminated any local restrictions limiting eligible veterans' access to non-institutional care, expanded coverage to geographic areas that currently do not offer non-institutional care services, implemented prioritization processes to ensure that veterans receive clinically indicated elective procedures according to their clinical needs, and reminded facilities of the requirement to either schedule a veteran's appointment or place the veteran on the electronic waiting list (EWL) within 7 business days of the appointment request.

VA's Program Response to OIG #1B: VA's estimated resolution timeframe is FY 2007. FY 2006 actions and next steps planned for FY 2007 are as follows:

FY 2006 Actions

- The Deputy Under Secretary for Health for Operations and Management reinforced the requirement to eliminate any local restrictions limiting eligible veterans' access to non-institutional care in accordance with Information Letter 10-2004-005, to Veterans Integrated Service Network (VISN) leadership in August 2006.
- The Care Coordination/Home Telehealth (CCHT) program, which provides non-institutional care to veteran patients, also extended the geographic range of services provided. CCHT programs exist in all VISNs. (Twenty-five percent of CCHT patients are in rural or highly rural areas.)
- VHA published Handbook 1140.6, *Purchased Home Health Care Services Procedures*, in July 2006, which includes policy on use of the EWL for veterans in need of and seeking home health care services.
- VHA issued Directive 2006-028, *Process for Assuring Timely Access to Outpatient Clinical Care*, in May 2006. The directive provides specific business rules requiring use of the EWL to identify veterans waiting for non-institutional care, including veterans entitled or not entitled to priority access.

Next Steps Planned for FY 2007

- VHA will implement effective measurement systems to evaluate the extent to which geriatric evaluations are occurring.
- With publication of the new VHA Directive, *Outpatient Scheduling Processes and Procedures*, individuals with electronic access to schedule appointments and place patients on the EWL will be required to document completion of standardized national training to assure their competency and ongoing compliance.
- VHA is exploring the feasibility of developing computer functionality to help automate appointment scheduling for new enrollees who want to schedule an appointment on their initial application for enrollment.
- In the interim, VHA is using manual procedures to assure that veterans desiring an appointment are appropriately processed.

OIG #1C—Applying Sound Business Practices

a. Clinical Staffing Guidelines

VA needs assurances that medical staffing levels are adequate and that medical staff are available to meet needs. *Department of Veterans Affairs Health Care Program Enhancement Act of 2001*, P.L. 107-135, was enacted on January 23, 2002. The law requires VA to ensure that staffing for physicians and nurses at VA medical facilities is adequate to provide veterans appropriate, high-quality care and services. VHA Directive 2004-027, *Primary Care Direct Patient Care Time*, dated June 15, 2004, establishes requirements for determining maximum panel size for primary care and associate providers. A VHA Physician Productivity and Staffing Advisory Group developed a resource value unit-based model for measuring productivity of medical and surgical specialty physician providers. The development of a national specialty physician database to accurately define the physician workforce is expected to be completed in calendar year 2006. Several specialties are being analyzed. However, the absence of staffing standards for physicians and nurses continues to impair VHA's ability to adequately manage medical resources.

- As of November 2006, 9 of the 17 recommendations remain open from OIG's April 23, 2003, report, *Audit of Veterans Health Administration's Part-Time Physician Time and Attendance*, Report No. 02-01339-85, on physician staffing. OIG will close the remaining recommendations pending finalization of VA directive and handbooks 5005 (Staffing), 5007 (Pay Administration), and 5011 (Hours of Duty and Leave). According to the report, VA physicians who were not present during their scheduled tours at VA medical facilities were not providing VA the services required by their employment. VA proposed developing a policy to meet the statutory requirement to ensure staffing for physicians and nurses is adequate, but reported that information management systems are inadequate to support nationwide standardized staffing plans for health care providers in varied settings. VA plans to review the issues at the local, network, and national levels, and to put systems for the collection and analysis of required information in place, but not until September 2009.
- OIG's August 13, 2004, *Healthcare Inspection, Evaluation of Nurse Staffing in Veterans Health Administration Facilities*, Report No. 03-00079-183, reported that managers could have managed staffing better in providing patient care if VHA had developed and implemented consistent staffing methodologies, standards, and data systems. As of November 2006, 11 of 15 recommendations remain open. The remaining 11 recommendations will be closed pending the finalization of a directive addressing nurse staffing issues.
- OIG's August 11, 2004, report, *Issues at VA Medical Center Bay Pines, Florida and Procurement and Deployment of the Core Financial and Logistics System (CoreFLS)*, Report No. 04-01371-177, cited that managers did not effectively communicate productivity goals to measure physician productivity. The Radiology Service did not monitor productivity by the contract service provider and an external VHA consultant could not determine the Pulmonary Clinic workload. As of November 2006, one recommendation remains open. The Deputy Under Secretary for Health, in

conjunction with the Deputy Under Secretary for Health for Operations and Management, needs to develop and implement productivity standards for physicians as directed by the *Department of Veterans Affairs Health Care Programs Enhancement Act of 2001*, P.L. 107-135.

- OIG's March 23, 2006, report, *Evaluation of Time and Attendance of a Full-Time Physician at the John J. Pershing VA Medical Center Poplar Bluff, Missouri*, Report No. 05-03271-113, showed that problems with physician time and attendance requirements persist. The medical center needed to ensure that a full-time physician was properly charged leave for periods of unauthorized absences. As of November 2006, we closed the one recommendation we made to address the physician's pattern of tardiness, extended lunch breaks, and early departures. However, based on the reports cited above, physician time and attendance remains a major management challenge.

VA's Program Response to OIG #1C (a.): VA's estimated resolution timeframe is FY 2007. FY 2006 actions and next steps planned for FY 2007 are as follows:

FY 2006 Actions

- VHA completed the final draft of a directive on staffing plans. The directive does the following:
  - Requires all facilities to develop staffing plans for various clinical care settings.
  - Contains national staffing guidance for nursing and physician primary and specialty care.
  - Requires national roll-up and analyses of staffing plans and patient outcomes.
- VHA developed the VA Nursing Outcomes Database (VANOD) with standardized data definitions, data entry, data extraction, and report generation.
- VHA developed productivity goals for the Radiology Service.

Next Steps Planned for FY 2007

- VHA will continue development and enhancement of the VANOD.
- VHA plans to develop national staffing guidance for other disciplines.
- VHA will issue new policy guidance on adjustable work hours for part-time physicians. This policy would provide guidance to accommodate varying VA patient care needs and part-time VA physicians who have VA or non-VA patient care, research, or educational responsibilities that make adherence to the same regularly scheduled tour of duty each pay period difficult.

b. Medical Outcome Measures

Veterans should receive high-quality medical care. Improvements in the measurement and use of medical outcomes data will provide opportunities for VHA to improve the health care provided to veterans. VHA will continue to develop and implement appropriate medical outcome measures, consistent with industry and Government standards that demonstrate the level of care VA provides.

- OIG reviewed colorectal cancer detection in VHA health care facilities and issued *Healthcare Inspection, Colorectal Cancer Detection and Management in Veterans Health Administration Facilities*, Report No. 05-00785-76, dated February 2, 2006. According to the American Cancer Society, colorectal cancer is the second leading cause of cancer deaths in the United States. Screening is crucial since it is one of the most treatable cancers, if detected early. However, we found that the length of time from presentation to diagnosis was excessive, and VHA has not established timelines for diagnosis. The Under Secretary for Health concurred with our findings and agreed to collect data and establish timelines to calculate performance measures and supporting indicators to monitor the timeliness of colorectal cancer diagnosis. As of November 2006, all three recommendations remain open pending the establishment of appropriate metrics to evaluate and improve the timeliness of diagnosis, implementation of prioritization processes to ensure that high-priority patients receive diagnostic colonoscopies according to their clinical needs, and implementation of a consistent notification requirement for patients undergoing diagnostic testing.

VA's Program Response to OIG #1C (b.): VA's estimated resolution timeframe is FY 2007. FY 2006 actions and next steps planned for FY 2007 are as follows:

FY 2006 Actions

- The VHA Office of Quality and Performance developed plans to report data on diagnostic delays quarterly, providing the mean time from a positive, non-colonoscopy, colorectal cancer screen to colonoscopy as a metric to track VHA-wide delays and improve the timeliness of colorectal cancer diagnoses.
- External Peer Review Process (EPRP) collection for diagnostic delays began in the first quarter of 2006. VA produced preliminary metrics.
- Participants in the Colorectal Cancer Care Collaborative (C4) projects are capturing three core measures to improve the quality of care and increase adherence to evidence-based care in the diagnosis of colorectal cancer:
  - Time from positive fecal occult blood test (FOBT) to colonoscopy performed or paid for by VA (for colonoscopies within 1 year).
  - The number of colonoscopies performed or paid for by VA within 90 days after positive FOBT (for colonoscopies within 1 year).
  - The number of positive FOBTs without a follow-up colonoscopy. C4 measures are designed for facility-level performance improvement by pilot facilities.
- VHA disseminated facility-based quality improvement measures and tracking tools in September 2006.

Next Steps Planned for FY 2007

- VHA will continue collection and analysis of EPRP data related to colorectal cancer diagnostic delays.
- VHA will proceed with Phase 2 of the C4 project, in which teams will study treatment of colorectal cancer. VHA expects to have recommendations and outcome measures once the collaborative project is finished in 2007.

c. Budget Process

VHA is challenged to align programmatic budget and financial execution with relevant outcomes, while remaining committed to providing quality health care to veterans. Budgeting and planning for VA health care is extremely complex and compounded by continuing uncertainty, from year to year, of the number of patients who will actually seek care from VA. Additionally, the limitations of VHA's current financial management and workload measurement systems hinder the ability to accurately measure specific program financial performance, and use financial metrics in decision analysis processes.

- The OIG *Report of Audit - Congressional Concerns over Veterans Health Administration's Budget Execution*, Report No. 06-01414-160, dated June 30, 2006, addressed congressional concerns about VHA budget execution processes. At three VISNs reviewed, officials were deferring non-recurring maintenance projects and equipment purchases as a means of establishing reserves in case the funds might be needed at the end of the budget year to cover patient care operations. In addition, one VISN was anticipating a budget shortfall of $163.1 million in FY 2006. We made recommendations to strengthen VHA budget processes, address potential shortfalls, and assess VHA-wide resource allocations. As of November 2006, all four recommendations remain open.

VA's Program Response to OIG #1C (c.): VA's estimated resolution timeframe is FY 2007. FY 2006 actions and next steps planned for FY 2007 are as follows:

FY 2006 Actions
- VHA assessed the VISN actions to ensure they maximized efficient and effective patient care.
- The VHA Chief Financial Officer routinely monitored all VISNs' resources throughout the year.
- VA submitted quarterly reports to Congress identifying progress achieved toward financial and program performance goals.

Next Steps Planned for FY 2007
- The VHA Finance Committee will continue to provide ongoing oversight of network financial execution, and expects to complete this by December 2006.

d. VA Disbursement Agreements with Affiliated Medical Schools

OIG's report, *Audit of VA Disbursement Agreements with Affiliated Medical Schools*, Report No. 05-01234-25, issued in November 2006, states that controls for administering disbursement agreements, which allow affiliated medical schools to administer salaries and fringe benefits for residents training at VA medical centers, need strengthening. We identified weaknesses at four medical centers in resident timekeeping, fiscal, and oversight procedures. The weaknesses included allowing residents to work at affiliated

medical facilities during VA-paid time and paying medical school disbursement agreement bills that were inaccurate.

- VA medical centers had not complied with operational and oversight requirements on disbursement agreements, and VHA's Office of Academic Affiliations had not provided sufficient guidance to the medical centers. As a result, VA had no assurance it received its proportionate share of resident services in some programs or that medical center disbursement agreement programs were effectively managed. Program management issues could be improved by updating and revising all policies and procedures pertaining to disbursement agreements, and ensuring compliance with operational and oversight requirements outlined in VHA policy. We made four recommendations to address program management issues recommendations, which remain open as of November 2006.

VA's Program Response to OIG #1C (d.): VA's estimated resolution timeframe is FY 2008. VHA will implement OIG final report recommendations on disbursement agreements for next steps planned for FY 2007.

OIG #2—BENEFITS PROCESSING

OIG #2A—State Variances in VA Disability Compensation Payments

OIG's May 19, 2005, report, *Review of State Variances in VA Disability Compensation Payments*, Report No. 05-00765-137, concluded that some veterans' disabilities are more susceptible to variations in ratings. According to the report, variations resulted from a disability-rating schedule based on a 60-year-old model and some diagnostic conditions, such as post-traumatic stress disorder (PTSD), that lend to more subjective decision-making practices. We made eight recommendations for VA to take to ensure fair equitable disability compensation payments. Specifically, we recommended that the Veterans Benefits Administration (VBA) conduct a scientifically sound study using statistical models, such as a multi-variant regression analysis, of the major influences on compensation payments to develop baseline data and metrics for monitoring and managing variances, and use this information to develop and implement procedures for detecting and preventing unacceptable payment patterns.

- VBA is improving training and reference materials on PTSD disability claims development and rating procedures for claims processing personnel. VBA has stressed to VA regional offices (VARO) the importance of oversight of benefits determinations.
- In May 2005, VA awarded a contract to the Institute for Defense Analysis (IDA) to conduct a scientific study to analyze variances of compensation payments. On June 5, 2006, VBA reported it will take appropriate action upon receipt of results of the study.
- In October 2005, VBA formed a rating consistency analysis work group to develop methods and data for evaluating and monitoring variances in disability grants, denials, and ratings. The target completion date for the work group's initial recommendations was August 2006. However, the results of the analysis addressing causal relationships and influencing factors will not be completed prior to January 2007.
- In May 2006, VHA released 14 medical examination templates for use by VHA physicians to accurately solicit medical information needed for rating examinations, and planned a final release of approved and revised templates.
- VA has undertaken a 1-year research study to evaluate military service member and veteran awareness of and access to VA benefits and services, and to recommend improvements for outreach for underserved veteran populations. VA expects results will be available in December 2006.

As of November 2006, three of eight recommendations remain open. OIG will close the remaining recommendations upon receipt of documentation showing: (1) that a scientifically sound study has been conducted and the information gathered was used to develop and implement procedures for detecting and preventing unacceptable payment patterns; (2) final and improved templates; (3) an agreement on the mandatory use of templates after development and release to the field; and (4) the completed Office of

Policy, Planning, and Preparedness research study with the findings and recommendations.

VA's Program Response to OIG #2A: VA's estimated resolution timeframe is FY 2008. FY 2006 actions and next steps planned for FY 2007 are as follows:

FY 2006 Actions

- VA contracted with the IDA to conduct a scientific study of the major influences on compensation payments to develop baseline data and metrics for monitoring and managing rating variances.
- VBA's rating consistency analysis work group is drafting a plan to monitor decision-making consistency to conduct an accurate and focused analysis. Initial results of the analysis, in terms of causal relationships and other influencing factors, will not be completed prior to January 2007.
- Staff from the Compensation and Pension Examination Program (CPEP)[1] and VBA's Compensation and Pension (C&P) Service began developing templates for C&P examinations to ensure that the medical evidence captured will enable consistent evaluation of disabilities. The templates are being tested and released to the field in the order of frequency of use.
- As required by the *Deficit Reduction Act of 2005,* P.L. 109-171, VBA will monitor the ongoing research study of veteran awareness. Findings are expected by December 2006.

Next Steps Planned for FY 2007

- VBA will take appropriate action upon receipt of the IDA study report (expected October 2006).
- VBA will monitor consistency on an ongoing basis.
- VA will work on full deployment and mandatory use of templates.
- VBA will take appropriate action based on findings from the research study.

OIG #2B—Fiduciary Program

The OIG report, *Audit of Veterans Benefits Administration Fiduciary Program Operations,* Report No. 05-01931-158, dated June 27, 2006, disclosed that VBA needed to improve fiduciary program case management to reduce the risk of misuse or theft of beneficiaries' funds. VARO staff needed to improve field examinations, monitoring of fiduciaries, and periodic accountings; verify beneficiary assets; and require documentation of some fiduciary-reported expenses.

- Fiduciary surety bonds were not always required or bond values were not sufficient to protect the value of beneficiary estates and income. Some fiduciaries and attorneys

[1] CPEP is an office jointly staffed by VBA and VHA tasked to coordinate and lead efforts for change in the C&P examination process.

charged excessive fees, and VA staff needed to more closely supervise income and expenditures of direct-pay beneficiaries.

- OIG estimated that payments and estates totaling $435 million for 8,918 beneficiaries were not adequately protected, and payments and estates valued at $80.2 million for 2,126 beneficiaries could be at risk of fraud. As of November 2006, one of seven recommendations to strengthen fiduciary program operations remains open. OIG will close the remaining recommendation upon receipt of documentation showing a determination was made on appropriate VARO fiduciary staff caseload levels and staffing requirements.

VA's Program Response to OIG #2B: VA's estimated resolution timeframe is FY 2008. FY 2006 actions and next steps planned for FY 2007 are as follows:

FY 2006 Actions

Action on the remaining recommendation is ongoing. VBA has implemented the following actions:

- Developed a Legal Instruments Examiner (LIE) training program to enhance skills needed to effectively conduct fiduciary oversight responsibilities.
- In May 2006, training was provided to 75 field staff via a National Training Conference.
- Developed a comprehensive LIE training syllabus for both introductory and refresher training.
- Revised and expanded the LIE Program Guide to include detailed explanations of the account review process and administrative duties of the LIE position.
- Based on the above actions, OIG closed the recommendation addressing the LIE training program in August 2006.

Next Steps Planned for FY 2007

- A work measurement study, which will include fiduciary program work products, is scheduled for the second quarter of 2007.
- VA will analyze results, examine fiduciary program staffing at the regional office level, and make recommendations regarding caseloads.

OIG #3—FINANCIAL MANAGEMENT

OIG #3A—Financial Management Controls

VA has received unqualified opinions in the annual consolidated financial statements (CFS) audits since FY 1999. However, the audit of VA's FY 2005 and FY 2004 CFS reported the lack of an integrated financial management system, financial operations oversight, and information technology (IT) security controls as material weaknesses. While VA has addressed some of our concerns, including the corrective action in FY 2005 to eliminate the judgments and claims reportable condition identified in the FY 2004 audit, the impact of the material weaknesses on financial operations demonstrates that VA faces major challenges in this area.

- The lack of an integrated financial management system, one of the areas of VA's noncompliance with the *Federal Financial Management Improvement Act of 1996*, P.L. 104-208, increases the risk of materially misstating financial information. Additionally, preparation of VA's CFS requires significant manual compilations and labor-intensive processes to prepare auditable reports. To address the issue, VA's Office of Finance has developed a centralized Web-based repository of information maintained in several different legacy systems, and is currently using this commercial financial statement reporting system to improve the accessibility of financial data, provide ad hoc reports, and secure access to customers within an integrated computer environment. VA used this system to prepare the FY 2006 CFS. The new system is a step toward reducing the risk of materially misstating financial information.
- VA believed that CoreFLS would resolve OIG concerns. Operational testing of CoreFLS began in October 2003 at three VA facilities, with implementation at further sites to be phased in, and full implementation scheduled for March 2006. After our August 2004 Bay Pines CoreFLS report [see OIG #1C (a.)] was issued, VA discontinued implementation of CoreFLS and the test sites resumed operation within VA's existing financial management system in early 2005. As of November 2006, three financial management and control recommendations remain open.
- VA is now developing the Financial and Logistics Integrated Technology Enterprise (FLITE) as an integrated financial management system to correct current financial and logistics deficiencies. However, FLITE will not be implemented until FY 2009.

VA's Program Response to OIG #3A: VA's estimated resolution timeframe is FY 2009. FY 2006 actions and next steps planned for FY 2007 are as follows:

FY 2006 Actions

- VA pursued two initiatives to mitigate the conditions that resulted in the audit findings regarding the lack of an integrated financial management system:

  Initiative #1: VA standardized and centralized the financial statement generation process using a commercial off-the-shelf (COTS) business tool.

  - The new tool and new procedures were successfully implemented during 2006, bringing standardization and greater integrity to the financial statement generation process.
  - VA submitted 3rd quarter financial statements and the Federal Agencies' Centralized Trial-Balance System II submission using this software and used this software to prepare the consolidated financial statements during the 4th quarter of 2006.

  Initiative #2: VA prepared a detailed analysis of major financial system interfaces to identify and initiate correction of any deficiencies in reconciliation, internal controls, security, and other areas.

  - To correct any reconciliation issues, VA is implementing a data warehouse to capture relevant interface and system data and produce both high-level and detailed information on the status and health of financial system interfaces.
- VA is standardizing business processes for finance and logistics. The final deliverable will be a listing of standardized business processes to be implemented across VA.
- As it pertains to the open financial management and control recommendations, VA completed a review of expenditures to the largest CoreFLS vendors and completed a review of all travel expenditures submitted by BearingPoint, one of the vendors.

Next Steps Planned for FY 2007

- VA will use the COTS tool to further enhance the preparation and generation of financial statements and reports.
- VA will complete the analysis of the financial system interfaces in 2007. The focus of the project will move to incorporating these interfaces into the data warehouse effort.

OIG #3B—Medical Care Collections Fund

OIG's December 1, 2004, report, *Evaluation of Selected Medical Care Collections Fund First Party Billings and Collections*, Report No. 03-00940-38, on the quality and accuracy of Medical Care Collections Fund actions identified that 89 percent of cases reviewed for certain veterans receiving C&P benefits had debts referred inappropriately to VA's Debt Management Center. Inaccurate or incomplete eligibility information about the veterans' C&P awards in Veterans Health Information Systems and Technology Architecture (VistA) system caused the errors.

- VHA and the Chief Business Office (CBO) are developing new tools to ensure accurate eligibility information is available to medical center staff making billing decisions. In the interim, CBO monitors first-party debts each quarter that were established inappropriately. The rate of inappropriately established first-party debts remains significant, including 80 percent for the 4th quarter of FY 2005. As of November 2006, one of four recommendations remains open pending the results of the deferred update of C&P data in VHA systems and documentation of reductions in the amount of actual inappropriately established debts.

VA's Program Response to OIG #3B: VA's estimated resolution timeframe is FY 2007. FY 2006 actions and next steps planned for FY 2007 are as follows:

FY 2006 Actions

- VA's 1st quarter 2006 review found that 11,576 bills were potentially issued in error to veterans. After reviews at VA medical centers, 5,139 first-party copayment bills were cancelled, resulting in $99,000 being generated in refunds to veterans.
- VA implemented the Web Hospital Inquiry (WebHINQ) application, which allows VHA to retrieve from VBA's information systems more definitive disability codes, the current and original effective dates of a veteran's service-connected disability, and the effective date of the combined service-connected disability.
- The Health Eligibility Center (HEC) implemented procedures to ensure that review file records are monitored weekly and that pension awards and 50 percent or greater service-connected awards are identified for priority processing. A reporting mechanism was established to report this information monthly.
- VA completed enhancements of the HEC's information system to optimize electronic processing of solicited and unsolicited eligibility messages from VBA. This resulted in a reduction of records requiring manual processing from 671 records to 15 records per week. VA continues to place a high priority on reviewing and resolving records requiring manual review.
- VBA corrected a deficiency in WebHINQ logic for triggering C&P award changes to the HEC.
- The HEC completed a refresh of C&P data in HEC records identified as a VA pensioner or service-connected veteran.

Next Steps Planned for FY 2007

- VA will continue monitoring to ensure the error rate of veterans billed inappropriately is at an acceptable level – lowered to 10 percent.

OIG #3C—Permanent Change of Station Travel Program

The OIG report, *Audit of Alleged Mismanagement of VA's Permanent Change of Station Travel Program*, Report No. 06-00785-120, dated March 31, 2006, cited that strengthened controls over VA's permanent change of station (PCS) travel program were needed. Congress requested the audit based on 13 allegations of mismanagement by the Financial Service Center (FSC), which administers the PCS travel program.

- OIG substantiated 9 of the 13 allegations. We found inadequate controls over PCS travel funds; deficiencies in FSC employees' knowledge of travel regulations, training, and experience; and problems in outsourcing PCS services, including services for VA employees needing to be relocated after Hurricane Katrina. We made 3 recommendations with 11 action items, of which 7 actions remain open as of November 2006. Recommendations focused on strengthening controls for obligating and advancing PCS funds, improving the ability to effectively administer the PCS travel program, and addressing issues pertaining to the planned award of a sole-source task order. Although VA has reported additional FY 2006 corrective actions,

we have not received documentation showing how the actions address the remaining OIG recommendations for improvement.

VA's Program Response to OIG #3C: VA's estimated resolution timeframe is FY 2007. FY 2006 actions and next steps planned for FY 2007 are as follows:

FY 2006 Actions

VA took the following actions:

- Reviewed the PCS travel cases nationwide ensuring that PCS travel funds were deobligated promptly, advances to transferring employees were for the appropriate amount and were promptly collected, and the appropriate amount of funds were obligated for PCS real estate expenses.
- Ensured that customer surveys were distributed to all transferred employees.
- Competed the requirement for entitlement counseling and voucher services for those affected by Hurricane Katrina under the provisions in the Federal Acquisition Regulations, Part 8.
- Changed the request for quotation to provide entitlement counseling and voucher services to a fixed-price indefinite delivery/indefinite quantity or a requirements task order that included tiered pricing or a rebate structure encouraging discounting pricing.

Next Steps Planned for FY 2007

VA plans the following actions:

- Continue monthly reviews of outstanding obligations and advances.
- Periodically analyze obligation and advance amounts and determine if adjustments are necessary.
- Maintain up-to-date standard operating procedures.
- Provide ongoing training for staff.
- Continue surveys of transferred employees.
- Conduct annual customer satisfaction surveys of VA facilities.
- Partner with Cartus, a relocation services company, to enhance the PCS process.
- Continue to monitor implemented corrective actions.

OIG #3D—Data Validity in Outpatient Scheduling

The *Government Performance and Results Act*, P.L. 103-62, requires that agencies develop measurable performance goals and report results against the goals. Successful implementation requires accurate and complete data. OIG's July 8, 2005, report, *Audit of Veterans Health Administration's Outpatient Scheduling Procedures*, Report No. 04-02887-169, found that VHA's outpatient scheduling procedures need to be improved to ensure accurate reporting of data on veterans' waiting times and facility waiting lists. VHA strives to schedule at least 90 percent of all next available appointments for veterans within 30 days. We found that VHA consistently did not meet this parameter. Because schedulers did not use the correct scheduling procedures, data on actual waiting times were understated, resulting in medical facility directors being unaware that 2,009

service-connected veterans waited longer than 30 days from their desired date of care. We found a recalculated average waiting time of 30.1 days was 44 percent more than the reported average waiting time of 20.9 days. As of November 2006, five of eight recommendations for improvement remain open. OIG will close the remaining recommendations once the revised national schedule directive is finalized and published, the software program for the consult-scheduling connection package is operational and has been installed in live accounts, and schedulers have received training on the EWL and VistA scheduling module.

VA's Program Response to OIG #3D: VA's estimated resolution timeframe is FY 2007. FY 2006 actions and next steps planned for FY 2007 are as follows:

FY 2006 Actions

- VHA revised Directive 2003-068 as Directive 2006-028, *Process for Ensuring Timely Access to Outpatient Clinical Care*.
- The revised directive continues previous requirements for scheduling and use of the EWL with emphasis on ensuring timely access for patients.
- A new directive on outpatient scheduling processes and procedures is in the final concurrence process.

Next Steps Planned for FY 2007

- The draft VHA directive on outpatient scheduling processes and procedures will provide more detailed business rules for: scheduling, use of EWL, Primary Care Management Module (PCMM), consult management, no-shows, clinic cancellations, registration, and enrollment.
- The directive also mandates demonstration and ongoing monitoring of the competencies of all staff with electronic access to schedule appointments and use EWL and PCMM, including the requirement to complete standardized national training.

OIG #4—PROCUREMENT PRACTICES

OIG #4A—VA Acquisitions for Other Government Agencies

OIG's May 5, 2006, report, *Audit of VA Acquisitions for Other Government Agencies*, Report No. 04-03178-139, cited two VHA contracting activities that did not comply with the *Economy Act*, as amended, 31 U.S.C. §1535, regulations when administering acquisitions for other Government agencies (OGAs) by charging the OGAs excessive service fees of about $8.1 million in FYs 2003 and 2004. Additionally, contracting officers inappropriately awarded 35 interagency contracts valued at about $15 million that were not within the scope of VA's mission.

- VHA and the Office of Acquisition and Materiel Management (OA&MM) are addressing the recommendations to ensure compliance with the *Economy Act*, Federal Acquisition Regulations, and VA policy, and to centralize management of interagency acquisition programs under OA&MM. The Under Secretary for Health agreed to transfer management of interagency acquisitions under the *Economy Act* and the *VA-DoD Healthcare Resources and Emergency Operations Act of 1982* to OA&MM. As of November 2006, 6 of 14 recommendations remain open.

VA's Program Response to OIG #4A: VA's estimated resolution timeframe is FY 2007. FY 2006 actions and next steps planned for FY 2007 are as follows:

FY 2006 Actions

VA took the following actions:

- New acquisitions for OGAs have been suspended in VHA since January 2006.
- VHA field offices are transitioning contracts for OGAs to OA&MM, or, in the case of Cooperative Administrative Support Units, to the General Services Administration.
- VA obtained quarterly financial reports to ensure that expenses and revenues were appropriately reconciled.

Next Steps Planned for FY 2007

- VHA will perform a final closeout and reconciliation of all procurements for OGAs.

OIG #4B—Acquisition of Medical Transcription Services

The OIG report, *Audit of the Veterans Health Administration's Acquisition of Medical Transcription Services*, Report No. 04-00018-155, dated June 14, 2006, cited that using speech recognition technology to transcribe medical reports in-house as an alternative to outsourcing to contractors could resolve security concerns about patient health care information and reduce costs by as much as $6.2 million annually.

- VHA medical facilities did not adequately verify supporting information when approving invoices for payment, which resulted in overpayments to some contractors. In addition, facilities did not ensure patient health care information sent to transcription contractors was protected against unauthorized access or use. As of

November 2006, all four recommendations to address these issues remain open. VHA needs to follow through on efforts to evaluate the various speech technologies available. VHA should coordinate the acquisition of medical transcription services VHA-wide to ensure comparable rates are paid for the same services and at the most economical rates, contracting officer technical representatives conduct independent line counts, and all contracts specify limitations on the access to VHA data at contractor facilities.

VA's Program Response to OIG #4B: VA's estimated resolution timeframe is FY 2007. FY 2006 actions and next steps planned for FY 2007 are as follows:

FY 2006 Actions

- VHA convened a work group to review market research and field data and to prepare a recommended procurement strategy for the approval of the Under Secretary for Health.

Next Steps Planned for FY 2007

- VHA will support the contracting officer(s) and program manager(s) responsible for implementing the procurement strategy during the procurement process.

OIG #4C—Contracting for Health Care Services and Products

OIG's July 26, 2006, review, *Audit of Allegations at the Health Administration Center Denver, CO*, Report No. 06-00116-177, substantiated an anonymous allegation that a VA Health Administration Center (HAC) contracting officer exceeded the $25,000 warrant authority when authorizing 14 purchases for IT services totaling $2.1 million. We made one recommendation, with five action items, to improve HAC contract management. As of November 2006, all five actions are closed. However, based on the reports cited in this section, contracting issues remain a major management challenge.

VA's Program Response to OIG #4C: FY 2006 actions are completed. Per the OIG report, the HAC's actions subsequent to the 14 purchases were appropriate. VHA has addressed the five recommendations and considers this a closed issue.

OIG #4D—VA Central Office Acquisition Issues

Serious contracting, planning, and project management issues had been identified in a congressionally mandated study. On September 30, 2005, OIG issued *Audit of VA Acquisition Practices for the National Vietnam Veterans Longitudinal Study*, Report No. 04-02330-212.

- To conduct the audit, OIG assessed the effectiveness of the procurement and project management processes used for the National Vietnam Veterans Longitudinal Study (the Study). Congress established the requirement for the Study in the *Veterans Benefits and Health Care Improvement Act of 2000*, P.L. 106-419. The purpose of the Study was to provide information on the long-term effects of PTSD among

Vietnam Era veterans and on the utilization and effectiveness of VA medical services for PTSD.

- The Study was not properly planned, procured, or managed by OA&MM Acquisition Operations Service contracting officials, VHA project managers, and other responsible officials. The Study contract solicitation, award, and administration did not protect VA's interests, demonstrate sound business practices, or comply with Federal and VA acquisition regulations. The justification for the sole-source contract was inaccurate. This contract had an inadequately defined statement of work and deliverables and was based on inadequately developed cost estimates. The contracting officer did not ensure that negotiated prices for the contract and subsequent modifications were reasonable. In addition, the contracting officer and the contracting officer's technical representative did not effectively administer the contract. Payments were not tied to definitive requirements or substantial deliverables, as is appropriate for a fixed-price contract. Instead, the contracting officer authorized payments for unspecified levels of effort.
- OIG recommended that the Under Secretary for Health and the Assistant Secretary for Management initiate formal acquisition planning and proper contracting processes to expeditiously and successfully complete the Study and ensure that assigned project management and contracting staff have the required knowledge and skills to effectively plan, procure, administer, and manage the Study in accordance with pertinent legal, procedural, and technical requirements; take appropriate administrative action against officials responsible for the contracting and project management problems associated with the uncompleted Study; and work with the General Counsel to secure the appropriate disposition of equipment and other assets in the contractor's possession or to recover the value of the equipment from the contractor. As of November 2006, four of six recommendations remain open.
- The OIG August 2004 CoreFLS System review [see OIG #1C (a.)] reported VA did not adequately contract for or monitor the CoreFLS project or protect the Government's interests. We identified systemic inadequacies in the contracting processes and serious weaknesses in contract development. OIG made 66 recommendations in the report. Twenty-nine recommendations related directly to procurement issues. As of November 2006, 12 of 29 recommendations remain open.

VA's Program Response to OIG #4D: VA's estimated resolution timeframe is FY 2007. FY 2006 actions and next steps planned for FY 2007 are as follows:

FY 2006 Actions

- VHA identified alternatives that could meet the intent of assessing mental health status, including the prevalence and effects of PTSD, in Vietnam (and other era) veterans. A final decision is still pending about which of the following approaches to pursue:
  - Use the Vietnam Era Twin (VET) Registry. The VET Registry was created to address questions about the long-term health effects of Vietnam service. The registry has evolved into a resource for genetic epidemiologic studies of mental

and physical health conditions. Because the VET Registry does not include women, complementary studies of women veterans would be needed.

- Use Findings from a VA-Department of Defense (DoD) Operation Iraqi Freedom (OIF) Study. A currently funded prospective study of OIF military personnel could provide insight into the onset and progression of PTSD as well as other mental and physical health consequences of service for veterans of current and future conflicts.
- Rely on Other Research. Significant research on PTSD has improved treatment and diagnosis techniques, and these findings can provide valuable information applicable to all veterans who serve in combat.
  – To improve VA's clinical care for veterans with readjustment problems, VA initiated several new projects, including collaborations with DoD and the National Institutes of Health, about the effects of combat.

  – Currently published and future findings should result in new therapies to address the issues of readjustment to civilian life or return to military service for all veterans, including Vietnam war veterans.

Regarding OIG's August 2004 CoreFLS System Review, VA did the following:

- VA began developing a new program, the Financial and Logistics Integrated Technology Enterprise (FLITE).
- The FLITE program will employ contracting methods that incorporate practices designed to address OIG's concerns.

Next Steps Planned for FY 2007

- Negotiations with Research Triangle Institute, the contractor for the longitudinal study, to close out the existing contract are continuing. These should be completed by December 31, 2006.
- VHA will choose one of the three approaches for assessing mental health status.

Regarding OIG's August 2004 CoreFLS System Review, VA plans to do the following:

- Use integrated process teams to develop acquisition plans and performance work statements.
- Use contract review boards to ensure contracts are developed, awarded, and administered properly.

OIG #4E—Vocational Rehabilitation and Employment Contracts

OIG's February 1, 2005, *Evaluation of Veterans Benefits Administration Vocational Rehabilitation and Employment Contracts*, Report No. 04-01271-74, reported that VA awarded over 240 vocational rehabilitation and employment (VR&E) contracts to provide evaluation, rehabilitation, training, and employment services to veterans. We concluded that VA was at risk of paying excessive prices for these contract services. Prices for similar services from the same contractors varied significantly compared to prior contracts. Base year price increases ranged from 23 to 314 percent. Voluntary price reductions received from 25 contractors showed that contracting costs could have been

reduced as much as 15 percent, which would have saved $6.8 million of $45 million in expenditures.

- VA is near completion of a national survey to address the recommendation on quality assurance review deficiencies. VA is also completing actions needed to address the recommendation on maintaining adequate contract payment internal controls. We made additional recommendations to ensure that task order files include proper contracts, require documentation and support for contractor selection when higher prices are paid for services, and ensure that contracting staff has the requisite skills and training to effectively perform assigned duties. As of November 2006, two of seven recommendations remain open pending receipt of documentation showing new contracts are being competed, actions have been taken to negotiate lower prices with contractors, and the new business structure has been pilot tested.

VA's Program Response to OIG #4E: VA's estimated resolution timeframe is FY 2008. FY 2006 actions and next steps planned for FY 2007 are as follows:

FY 2006 Actions

- VA began work to re-procure the National Acquisition Strategy (NAS) contracts. These contracts provide necessary counseling services required for veterans in the VR&E program.
- VA awarded a facilitation contract to Acquisition Solutions, Inc., to assess various acquisitions strategies and identify the risks and benefits for each alternative.

Next Steps Planned for FY 2007

- Since new contracts were not in place by the end of 2006, VA will exercise the 4th and final option year on the current contracts pending a satisfactory price reasonableness determination.
- VA will work with the integrated process team to conduct extensive, more comprehensive market research to make a more informed business decision regarding the acquisition strategy.
- Based on these activities, VA will solicit for NAS services with the goal of awarding contracts by the end of 2007.

OIG #4F—VHA Sole-Source Contracts

OIG's February 2005 summary report, *Evaluation of VHA Sole-Source Contracts with Medical Schools and Other Affiliated* Institutions, Report No. 05-01318-85, discussed issues identified during preaward reviews of proposals, postaward reviews, and reviews conducted as part of OIG's Combined Assessment Program. This summary report focused OIG's collective findings and recommendations since 2000 for improvement in the procurement of health care resources. The report addressed general contracting issues including poor acquisition planning, contracting practices that interfered with the contracting officers' ability to fulfill their responsibilities, and contract terms and conditions that did not protect VA's interest; contract pricing issues that resulted in VA overpaying for services; and legal issues, including conflict of interest violations,

improper personal services contracts, terms and conditions that were inherently Governmental, and contracts that were outside the scope of 31 U.S.C. § 8153 authority. For example, in 2003 the VHA Resource Sharing Office reported that 99 contracts valued at $500,000 or more were awarded. Only 3 of the 99 were referred for a preaward review.

The Under Secretary for Health concurred with the report's findings and recommendations to improve VHA's award and administration of these contracts. As of December 2006, OIG has closed this report.

VA's Program Response to OIG #4F: FY 2006 actions are completed. After VA developed policy that addressed the concerns raised by the OIG report, the Secretary signed policy on sole-source contracting in August 2006. The remaining recommendation to submit a legislative proposal for personal services contracting authority was recently implemented. All recommendations are now complete.

OIG #5—INFORMATION MANAGEMENT SECURITY AND SYSTEMS

OIG #5A—VA Information Security Program Reviews

For the past several years, OIG has reported vulnerabilities with IT security controls in our CFS audit reports; *Federal Information Security Management Act* (FISMA), P.L. 107-347 reports; and Combined Assessment Program reviews. Each year, we continue to identify repeat deficiencies and repeat recommendations that remain unimplemented. OIG's March 31, 2005, *Audit of the Department of Veterans Affairs Information Security Program*, Report No. 04-00772-122, reported that inadequate IT security controls for VA's financial management systems continue to place VA program and financial information at risk due to inadequate implementation and enforcement of access controls to financial management systems and data, improper segregation of duties for the staff that operate and maintain key IT systems, inadequate continuity planning for IT services, and inconsistent development and implementation of system change controls. All 16 recommendations remain open. OIG's September 20, 2006, *FY 2005 Audit of VA Information Security*, Report No. 05-00055-216, reaffirmed the 16 unimplemented recommendations, and added another VA action, bringing the total to 17 open recommendations as of November 2006. OIG has reported IT security as a major management challenge for the Department each year for the past 6 years.

- OIG recommended that VA pursue a more centralized approach, apply appropriate resources, and establish a clear chain of command and accountability structure to implement and enforce IT internal controls.
- Previously reported conditions that needed to be addressed include improving controls to prevent unauthorized access to data systems and misuse of sensitive information, defining data access classifications in employee position descriptions, completing employee and contractor background investigations, completing infrastructure protection plans, fully testing major data system continuity of operations plans, implementing an effective patch management system to protect against viruses and intrusions, completing installation of intrusion detection systems to monitor IT systems, and completing certification and accreditation of all systems.
- Other needed improvements include upgrading external connections to systems, strengthening configuration management, eliminating older operating systems incompatible with new security technologies, moving and consolidating VA central office data center operations, improving application and operating system change controls, restricting physical access to computer rooms, improving security of wireless devices, encrypting sensitive veteran data files, and improving the accuracy of information in VA's FISMA database.
- An OIG December 5, 2005, *Management Letter, Fiscal Year 2005 Federal Information Security Management Act Audit Network Operations Center (NOC) and Security Operations Center (SOC),* Report No. 05-00055-34, reported deficient equipment controls and records for a 10-year period resulted in the inability to account for about 400 items of IT equipment valued at $1 million at a VA medical facility. Inadequate equipment inventory controls also precluded VA from determining if the 181 computers among the unaccounted equipment contained

sensitive data that could be disclosed in violation of the *Privacy Act*. As of November 2006, all seven recommendations to address these issues are closed. However, the issue of controls continues to be an area of concern that will be addressed in ongoing reviews because it is central to information security.

- OIG's March 6, 2006, reports of wireless network vulnerability assessments at two medical centers (*Wireless Network Vulnerability Assessment at the VA Medical Center Dallas, TX*, Report No. 05-00123-97, and *Wireless Network Vulnerability Assessment at the VA Medical Center San Antonio, TX*, Report No. 05-00123-98) identified inadequate access controls for wireless technologies and weak operating system configurations based on penetration test results. As of November 2006, two of four recommendations remain open pending deploying an intrusion detection system and providing training to the staff responsible for wireless network security. For the second facility, we closed the remaining three of four recommendations in October 2006, for the strengthening of operating system configurations restricting information leakage, deploying an intrusion detection system and coordinating detection activities, and providing training to the staff responsible for wireless network security. However, OIG still considers this issue a major management challenge.

VA's Program Response to OIG #5A: VA's estimated resolution timeframe is FY 2007. FY 2006 actions and next steps planned for FY 2007 are as follows:

FY 2006 Actions

- VA created a new IT management structure, which gives the Chief Information Officer (CIO) the following:
  - Control over IT operational personnel and the IT budget. The CIO is now able to direct the remediation of IT deficiencies and implement the centralized enforcement/execution model envisioned by OIG.
  - Responsibility and authority (as delegated by the Secretary in a June 2006 memorandum) for information security responsibility policies, procedures, and practices.
- Corrective action has been taken for one of four recommendations made at one facility. Vulnerabilities noted in the report have been successfully remediated at this facility.
- For the other facility, corrective action was taken by the facility on two of four recommendations.
- Although vulnerabilities were identified at the Dallas and San Antonio VA medical facilities, VA is approaching this issue from a national perspective.
- From this perspective, VA has required its officials to adhere to Federal information processing standard encryption requirements, and VA's Office of Cyber and Information Security has begun assisting VHA facilities with network protection deployments.

Next Steps Planned for FY 2007

- The Department has begun and will continue to execute the data security assessment and strengthening of controls project plan, which was developed to remediate IT deficiencies.
- VA will issue new policy on use of wireless technology.
- VA will provide additional wireless training to the staff at one of the facilities.
- The other facility is planning to deploy a wireless intrusion detection system and will be providing its IT staff with wireless security training.
- Corrective action for the two remaining recommendations is planned for completion in 2007.

OIG #5B—VA Information Security Controls

OIG's July 11, 2006, *Review of Issues Related to the Loss of VA Information Involving the Identity of Millions of Veterans*, Report No. 06-02238-163, reviewed the circumstances surrounding the theft of a personally-owned laptop computer and external hard drive, which was reported to contain personal information on approximately 26 million veterans and United States military personnel, from the home of a VA employee.

- OIG found that while the employee had authorization to access and use large VA databases, the employee was not authorized to take VA data home and did not encrypt or password protect the data. The notification process regarding the stolen data was not appropriate or timely. We found that senior officials failed to recognize the magnitude of the incident and did not identify it as a high priority item, and that information security officials acted with indifference and little sense of urgency.
- We also found that VA policies and procedures do not adequately protect personal or proprietary data. None of the policies prohibited the removal of protected information from the work site or storing protected information on a personal computer. Lastly, although we have reported vulnerabilities with IT security controls for several years, we found that information security control weaknesses remain uncorrected.
- OIG recommended that the Secretary take whatever administrative action deemed appropriate concerning the individuals involved; establish one clear, concise VA policy on safeguarding protected information when stored or not stored on VA automated systems; modify mandatory cyber security and privacy awareness training; ensure that all position descriptions are evaluated and have proper sensitivity level designations, and that required background investigations are completed in a timely manner; establish VA-wide policy for contracts that ensures contractors are held to the same standards as VA employees and that protected information used on non-VA automated systems is safeguarded; and establish VA policy and procedures that provide clear, consistent criteria for reporting, investigating, and tracking incidents of loss, theft, or potential disclosure of protected information or unauthorized access to automated systems. As of November 2006, four of five recommendations remain open.

VA's Program Response to OIG #5B: VA's estimated resolution timeframe is FY 2007. FY 2006 actions and next steps planned for FY 2007 are as follows:

FY 2006 Actions

- The Department completed four separate administrative investigations regarding the theft of a personally-owned laptop computer and hard drive from a VA employee's residence.
- All employees took privacy awareness and cybersecurity training.
- All laptops are being equipped with encryption technology.
- VA is offering data breach analysis services.
- The Secretary directed that all employees: (1) sign a "Statement of Commitment and Understanding" by July 21, 2006, regarding their understanding of the training, consequences for non-compliance, and commitment to protecting sensitive and confidential information in the Department; and (2) complete both cyber security and privacy awareness training by June 30, 2006. The actions cited were completed.
- VA issued a number of statements and five directives affecting the use of information by VA employees. These encompass such areas as telecommuting, the removal of sensitive data from VA facilities, and the use of and access to VA data outside VA facilities.

Next Steps Planned for FY 2007

- VA will modify cyber security and privacy awareness training to identify and provide an electronic link to all applicable laws and VA policies.

VA plans the following actions:

- An evaluation of all positions to ensure proper and consistent sensitivity level designations and timely completion of required background checks.
- Establishment of a VA-wide policy that ensures that contractor personnel are held to the same standards as VA employees regarding access to protected information, and that information accessed, stored, or processed on non-VA automated systems is safeguarded.
- Establishment of VA policy and procedures that provide clear, consistent criteria for reporting, investigating, and tracking information security incidents, including specific timelines and responsibilities regarding reporting and notification inside and outside VA.

OIG Contact and Staff Acknowledgments

OIG Contact	William F. Crandell (202) 565-7606
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